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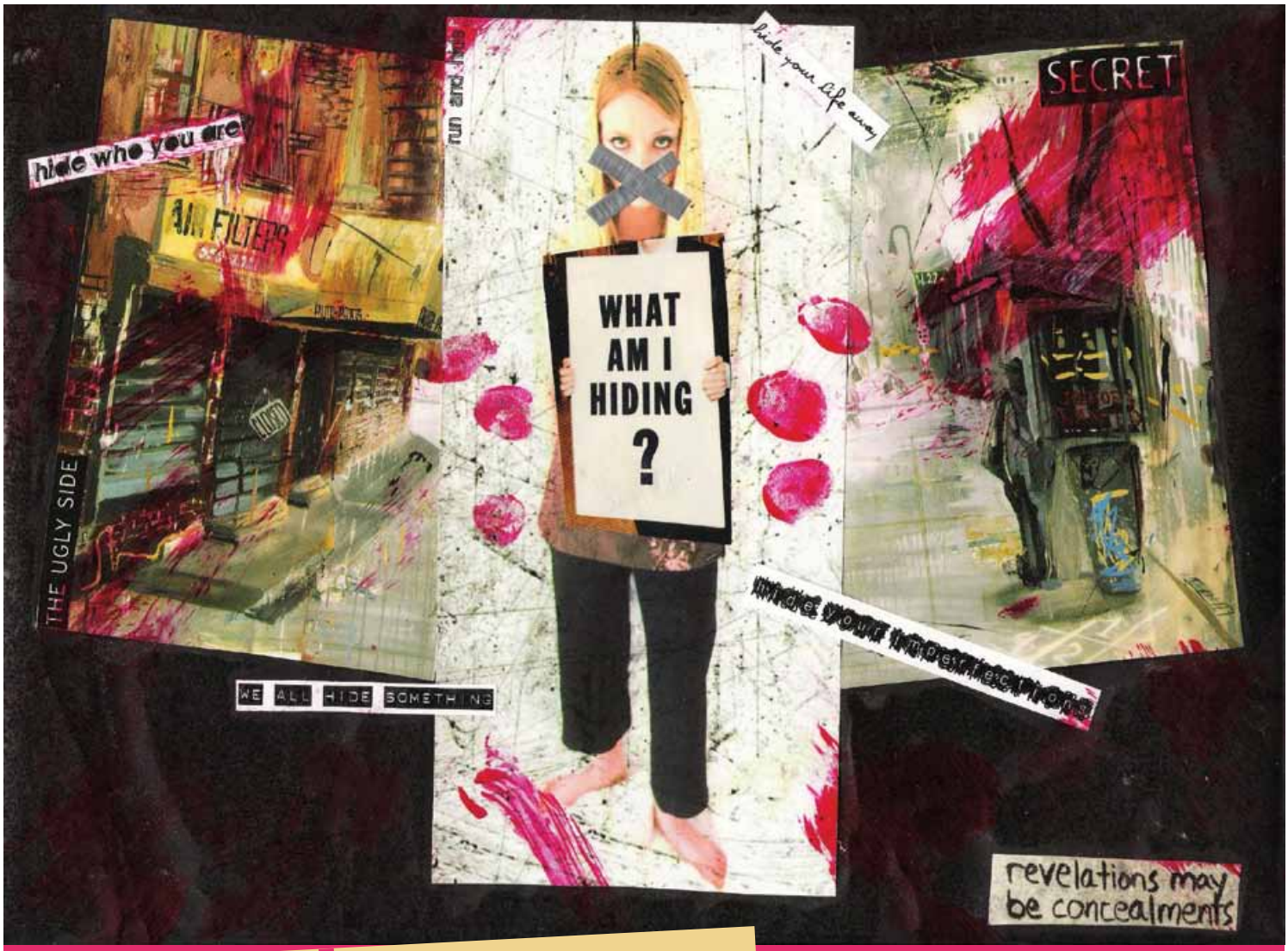

Mind the gap

Healthy transitions to adulthood

Growing pains The challenge of helping youth find their way

From uncomfortably numb to feeling alive Overcoming the legacy of residential schools

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Campus in crisis Support services help students make the grade

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What Am I Hiding?, Erin Schulthies, mixed media, 8.5" x 11"

Erin is an artist, writer and creator of all kinds from London, Ont. Visit her blog at daisiesandbruises.com.

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In Every Issue

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note from the editor

What happens to youth with mental health or substance use issues as they approach adulthood? What happens when they legally become adults if they have been getting services through the youth health system and are no longer eligible to receive them?

Between about age 13 and 24, young people go through a crucial developmental period. Most of them will make a successful transition to adulthood. They will complete their education, find jobs and stable housing and develop meaningful relationships. But about five to 10 per cent will struggle. In fact, mental health and substance use issues often emerge during this critical period.

Transition-aged youth who have received services from the youth system may need continued services and supports from the adult system. But traditional mental health and addiction services help youth and adults in separate systems of care, with few bridges between them. At a time when youth need help most, a lot of them lose services.

This issue of *CrossCurrents* takes a look at the unique needs of these emerging adults and what is being done in Canada and beyond to bridge the gap.

Enjoy this issue, and all the best to you in 2012.

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a view from CAMH

My first job as a full-fledged psychiatrist was with a team called Antenna in London, England. The team was set up by two psychiatric nurses to serve youth between 16 and 25. We provided assertive community treatment and first episode, crisis and case management, using a team and community development approach to help improve the lives of people with mental health issues in a very challenging inner-city district.

Before Antenna launched, a community group was formed to help decide on the program's focus. The group wanted services for this particular age group because it seemed that services which started at age 18 led to youth dropping out of care. The group suggested that one of the team's nurses serve as a community development worker to liaise with other youth services and to help them work with our clients. The group also recommended that our case managers work intensively with hospital wards to ensure a smooth transition between outpatient and inpatient care. Another suggestion was that rather than wait until youth turned 25, Antenna should work with other mental health teams so that clients could transition when they were ready for the care they needed.

Ultimately, the community group identified transitions as important; the service listened; and the outcome data are among the best for any service of this type. Taking care at transitions is common sense.

Fast forward a couple of decades to the present and the issue of transition-aged youth is again in the spotlight: In Ontario, $257 million have been granted toward child and youth mental health services. The Canadian Psychiatric Association has recognized child psychiatry as a separate specialty. The Centre for Addiction and Mental Health will soon open new inpatient beds for youth with concurrent disorders, backed by an outpatient day program. Youth mental health has become the focus of renewed interest and optimism in the media and in the political realm. So it's a good time to take a look at our practices.

If up to 70 per cent of adult mental health problems have their origins in childhood, then taking a life course approach to mental health services makes sense. But we have to ask: Is it useful to build silos such as child and youth, adult and geriatric psychiatry? Is chronological age, rather than need, what we should consider when we look at how services are organized? Should youth and adult services merge into teams like Antenna that specialize in dealing with transitions? The answers may not be what you think.

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Relational autonomy: Its value for adolescents and their families

Barbara Russell

"Heteronomy," a Greek word, means being ruled or governed by others. "Autonomy," on the other hand, means being self-governed. In *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society* (2003), bioethicists Willard Gaylin and Bruce Jennings describe the typical use of the term autonomy as "perverted" to convey how distorted the ethically important principle of autonomy has become—likely unintentional, but distorted nonetheless. Gayling and Jennings are also concerned about the tendency for individual autonomy to trump other liberal and communal values associated with health care, including that provided for adolescents.

Canadian philosopher Susan Sherwin points out that contemporary health care practices actually rely on agency, not autonomy. In a chapter published in *Readings in Health Care Ethics* (2000), she defines agency as the exercise of reasonable choice. Amenable to the real-world demands of hospitals, community clinics and individual therapist practices, agency is reflected in standard informed consent processes. A credible process includes adequately informing the client, ensuring that she is not being pressured or manipulated, verifying that she has the requisite level of cognitive capacity and tailoring these to the decision at hand.

With this said, however, ethics-related debates about adolescents in need of health care have been long-standing and loud. Although adult treatments may be ineffective or even harmful for young people, opinions differ about the legitimacy of adolescent consent, rather than parental consent, to participate in much-needed research. How much is "enough" capacity? How free are youth from parental expectations and demands? And as popular media stories highlight, opinions differ about adolescent consent for newly offered interventions that involve substantial discomfort and negative side-effects, but that may prevent foreseeable death (e.g., for refractory cancer).

Today's favoured version of autonomy is inadequate and inaccurate for health care purposes on several counts. First, it presumes that patients and clients are accustomed to decision-making and are articulate about their values and priorities. Second, it envisions adults as independent and self-sufficient individuals: "I decide for myself by myself." Third, autonomy assumes that patients and clients have more control over their treatment and care than they actually have. Fourth, autonomy hides the fact that treatment decisions are made in the context of certain arrangements that are beyond "the individual," including social (e.g., permitted sexual activities, familial norms), political (e.g., legislated age of majority, governmental policing/safety powers), and economic (e.g., private versus governmental health care coverage) arrangements.

In response to these limitations, Sherwin developed the concept of relational autonomy. Since autonomy is about authenticity and self-governance, a sensible starting point is to understand the human self. In the case of relational autonomy, Sherwin holds that we are all relational selves. We are inherently and inescapably social beings who are significantly shaped and modified within a web of interconnected (often conflicting) relationships. Throughout our lives, we are interdependent, not independent, and we rely on others; we are not self-sufficient. This is language very different from what we typically use and hear.

Relational autonomy fits especially well with adolescents-becoming-adults. The transition from adolescence to adulthood is, almost by definition, tumultuous. In a 2006 article in the *Bulletin of the Menninger Clinic*, psychiatrist Edward Poa notes that adolescents are unsure about what they want and tend to be experimental, but have few resources. Their relationships are uncertain, changing and many. Transitioning adolescents also tend to be sceptical about authority, which is important, given the involvement of parents, clinicians and social service agents in health care settings.

Swartz and colleagues examined the current phenomenon in which young adults who have completed their schooling continue to receive substantial financial and housing assistance from their parents, regardless of whether these young adults have a health problem or not. The study, published in a 2011 issue of the *Journal of Marriage and Family,* concluded that "parents [serve] as collaborators in their children's transition to adulthood, acting as scaffolding systems to help young people reach their goals and as safety nets to catch them before they fell too far."

Transitioning adolescents tend to be sceptical about authority, which is important, given the involvement of parents, clinicians and social service agents in health care settings.

In a 2009 study in the *Journal of Children and Family Studies* about the parents of transitioning adolescents with mental health difficulties, Jivanjee and colleagues identified a common lament among the 42 family members they interviewed. It was about the "bluntness" of the law, where various rights are legally gained on an arbitrarily chosen birth year (e.g., able to marry or leave the parental home at age 18, drink alcohol at age 19), despite the fact that the transition from adolescence to adulthood takes years. Many parents spoke of their hopes for their child to be included in different communities and groups, tempered by their worries about continued public stigma and discrimination. The parents also noted that they, too, were transitioning from parents-with-teenagers to parents-with-adult-children. This meant they needed to be treated differently as well.

The favoured version of individual autonomy is outmoded for health care settings. Relational autonomy is the stronger version because it better reflects how and why we actually make particular decisions. It is especially meaningful for transitioning adolescents because it accepts the uncertainty, variability and plurality of relationships and their influence on our evaluations of and decisions about health care options.

Mark de la Hey

Positive psychology may not help some personalities

Positive psychology exercises can actually bring people down if they have "needy" personalities, concludes a new study from York University in Toronto. Researchers defined needy people as those who are over-reliant on others and prone to feelings of helplessness. The study involved 772 adults from across Canada who were asked to perform one of three daily exercises: recalling five things they were grateful for over the course of the day, listening to three or four uplifting songs or recalling and writing about a particular memory from their early life (the control condition). They were also asked to complete questionnaires measuring depressive symptoms, physical symptoms, happiness and self-esteem. The results showed that participants who were highly self-critical experienced the greatest increase in happiness of all participants when they practiced the gratitude exercise. Self-critical participants also reported the greatest increases in self-esteem and larger decreases in physical symptom severity after both the gratitude exercise and the music exercise. Participants categorized as needy actually reported decreased self-esteem after the gratitude and music exercises and no improvement in happiness or physical symptoms. The authors had hypothesized that the music exercise would be of particular benefit to needy participants, so its failure was a surprise. They speculate that this failure might have occurred because the exercises were performed independently over the Internet and involved no interaction with other people, since needy people are known to "rely on having secure intimate bonds with others in order to experience well-being."

Journal of Positive Psychology, July 2011, v. 6(4): 260–272. Susan Sergeant and Myriam Mongrain, Department of Psychology, York University, Toronto, Ontario.

Group therapy can ease social anxiety

Although treatment for social anxiety disorder has been moving toward individual cognitive-behavioural therapy in recent years, new research from Rhode Island Hospital in Providence indicates that group therapy can be effective. For the study, 45 students with social anxiety disorder at the University of Colorado were assigned to receive eight weekly treatments of either cognitive-behavioural group therapy (CBGT) or group psychotherapy (GPT). Five participants in CBGT and one participant in GPT did not complete treatment. Overall, participants experienced improvement on measures of avoidance, fear and social anxiety severity, with no significant differences observed between those treated with CBGT and those treated with GPT. The authors had hypothesized that CBGT would prove to be the superior treatment, but the results indicate that GPT is a credible alternative for treating social anxiety. They see the current trend toward individual cognitive-behavioural therapy for social anxiety as being due to a lack of dissemination of CBGT, as well as high attrition rates and a lack of time to foster group dynamics in CBGT. However, the authors believe it might be possible to combine elements of the two types of group treatment to reduce attrition rates and improve the efficacy of treatment.

Depression and Anxiety, August 24, 2011, published online, doi: 10.1002/da.20877. Andri S. Bjornsson et al., Rhode Island Hospital, Providence.

Nurse burnout linked to workplace annoyance

Workplace annoyance can contribute to emotional exhaustion and burnout among nurses, whereas resilience can have a protective effect, according to new research from La Rioja University in Logroño, Spain. Researchers defined this annoyance as "a gradual state of psychological wear and tear or exhaustion that is not resolved by daily rest" and as "the sense of uncertainty at work, including reactions of insecurity, alertness and inconvenience." The study's findings are based on the responses of 200 nurses in northern Spain to questionnaires examining emotional annoyance, resilience, professional efficiency and cynicism. The results showed that cynicism and emotional annoyance contribute to the development of emotional exhaustion. Resilience and professional efficiency, on the other hand, were negatively correlated with the development of emotional exhaustion, implying that they have a protective effect. The authors see their results as supporting the theses of positive psychology which state that awareness of one's strengths and weaknesses and of the mechanisms needed to deal successfully with adverse situations can provide protection against emotional exhaustion. In light of these results, they recommend that efforts be made "to empower nurses and promote well-being through free training programmes and workshops within the health system." These workshops should train nurses to recognize and control factors that lead to emotional exhaustion, develop coping skills, exchange positive feedback with colleagues and supervisors and manage conflict and aggression.

International Nursing Review, September 19, 2011, published online, doi: 10.1111/j.1466-7657.2011.00927.x. Guadalupe Manzano Garcia and Juan Carlos Ayala Calvo, Department of Human Sciences and Education, La Rioja University, Logroño, Spain.

Indifference may explain why intoxicated people are mistake-prone

The reason why people are so mistake-prone when they are intoxicated has more to do with alcohol-induced indifference to mistakes than a failure to recognize them, according to new research from the University of Missouri in Columbia. The study involved 67 adults aged 21 to 35 who were assigned to receive an alcoholic beverage (vodka and tonic), a placebo beverage (diluted vodka and tonic) or a non-alcoholic beverage (the control condition). Participants were asked to complete a laboratory task requiring self-regulatory control while their brain activity was recorded on an electroencephalogram (EEG). The mood of participants given alcohol turned out to be less negative after the drink than at the study's outset, whereas those given the placebo reported feeling more negative, supporting the idea that alcohol dampens negative affect. The alcohol group participants were less accurate on the task than those in the placebo and control groups. While participants in the alcohol group turned out to be just as aware of their mistakes as participants in the other groups, they showed less of a negative reaction to those mistakes as measured on the EEG than was seen in the other two groups. The authors suggest that alcohol may muffle the "alarm signal" that normally follows a mistake, thereby limiting the efforts people ordinarily make to adjust their behaviour after a mistake.

Journal of Abnormal Psychology, May 23, 2011, doi: 10.1037/a0023664. Bruce D. Bartholow et al., Department of Psychological Sciences, University of Missouri, Columbia.

New cannabis use guidelines could reduce health harms

The introduction of public health guidelines for cannabis use could help reduce associated health harm, concludes a study from Simon Fraser University in Vancouver, B.C. Reviewing relevant publications on health harms of cannabis, researchers found that people who began using cannabis before age 16 were more likely to leave school early, use other illicit substances and develop dependence and mental illnesses such as depression. Frequent users, especially those who used daily, were more likely to engage in other illicit drug use, to drive after using cannabis and to develop dependence and mental illness, including impaired cognition, memory and learning performance. Five per cent of Canadian adult drivers report driving after cannabis use, and the evidence indicates that cannabis use impairs driving and can increase the risk of a motor vehicle accident. Based on these findings, the authors drew up a set of lower-risk cannabis use guidelines, comparable to low-risk drinking guidelines for alcohol. They conclude that the simplest way to avoid the risks associated with cannabis use is to abstain from use—but for those who do use cannabis, the guidelines include recommendations that the initiation of use be delayed until late adolescence or early adulthood, that frequent use (daily or near-daily) be avoided and that users should not drive until three to four hours after use.

Canadian Journal of Public Health, v. 102(5): 324–327. Benedikt Fischer et al., Faculty of Health Sciences, Simon Fraser University, Vancouver, British Columbia.

Community treatment orders don't affect attitude toward recovery

The use of community treatment orders does not appear to have a negative effect on clients' perceptions of their prospects for recovery, according to research from the University of Otago in Dunedin, New Zealand. Researchers interviewed 86 people with either schizophrenia or schizoaffective disorder about their mental and physical health and their views of recovery. Eighteen of the participants were under a community treatment order (CTO) at the time of the interview. Eighty-two per cent of participants believed that recovery from their mental illness was possible; in fact, 51 per cent considered themselves to be in recovery already. Participants who were under a CTO were no more or less likely to see recovery as a possibility or to see themselves as already being recovered than those who were not under a CTO, despite the fact that criteria for placement under a CTO include symptom severity and poor function. The authors speculate that the reason those under a CTO were not less optimistic about their prospects may be because the CTO is viewed as part of the treatment that helps a person manage their illness and achieve recovery, thus enhancing rather than diminishing their individual autonomy.

Australasian Psychiatry, September 17, 2011, published online, doi: 10.3109/10398562.2011.603330. Tess Patterson et al., Department of Psychological Medicine, University of Otago, Dunedin, New Zealand.

Romantic partner's friends influence youth drinking habits

The drinking habits of a romantic partner's friends have more influence on youth drinking behaviour than the drinking habits of the romantic partner or of the young person's own friends, according to a study from Pennsylvania State University in University Park. Researchers examined data about peer networks and drinking habits among 449 adolescent and teen couples from 94 schools across the United States, ranging from grade 7 to 12. They found that an increase in the frequency of drunkenness among a romantic partner's friends increased the frequency of a young person's drinking by 93 per cent, whereas a comparable increase in friends' or partners' drunkenness increased the frequency by 13 and 10 per cent, respectively. An increase in the frequency of drunkenness among a romantic partner's friends increased the risk of binge drinking by 81 per cent, and a comparable increase in friends' or partners' drunkenness increased the risk by 30 and 32 per cent, respectively. The authors speculate that the pronounced effect of a partner's friends on drinking behaviour has to do with the belief among youth that becoming friends with their partner's friends will strengthen the romantic relationship and gain them entry into a socially desirable peer group. Partners' friends also expose youth to new behaviours and opportunities which can motivate them to change their own behaviour.

American Sociological Review, v. 76(5): 737–763. Derek A. Kreager and Dana L. Haynie, Department of Sociology, Pennsylvania State University, University Park.

Growing pains

Struggles and innovations in serving transition-aged youth

By Melissa Vloet, Simon Davidson and Mario Cappelli

At least 60 per cent of young people with enduring mental health issues disengage from service during the transition between the youth and adult service systems.

The mental health of young people is increasingly fragile. In Canada, one in five children and youth are identified with a mental illness. It's a trend reflected in other countries. Policy leaders and researchers with the European Commission and the U.S. Department of Health and Human Services predict that mental illness will be one of the five most common causes of morbidity, mortality and disability among youth by 2020.

Statistics about transition-aged youth are particularly worrisome. According to a 2002 Statistics Canada report, suicide is the leading cause of non-accidental deaths among 15- to 24-year-olds, accounting for 24 per cent of all deaths in this age group.

Yet only a fraction of youth with mental health issues receive the supports and interventions they need. In response to this critical issue, the Mental Health Commission of Canada (MHCC) has identified child and youth mental illness as an area of key importance and is advocating for resources to improve prevention, preserve the well-being of young people and build capacity for a more resilient youth population and a healthier future for all Canadians.

Prioritizing youth mental health also reflects best practice standards developed by international experts in youth mental health like Dr. Patrick McGorry in Australia. In a 2007 issue of the *Medical Journal of Australia*, he writes, "Early, effective intervention, targeting young people aged 12–25 years … is required if we wish to reduce the burden of disease created by these [mental] disorders."

Youth between 16 and 25 moving to adult mental health services have been identified as a particularly vulnerable group for four reasons. First, the peak onset of mental illness occurs before age 25, and evidence indicates that youth who don't get treatment become "more vulnerable and less resilient" over time, according to Brenda Wattie, a member of the Canadian Mental Health Association Ontario Children and Youth Reference Group. Second, the greatest financial and institutional weaknesses in mental health services have been reported during the transition between youth and adult services. Third, international and Canadian researchers have identified a lack of integrated systems of care and co-ordinated service provision between youth and adult services. Finally, young people navigating service transitions also experience developmentally specific changes (e.g., relationships, housing, school, employment) that further complicate their ability to negotiate mental health journeys. As McGorry explains, "the maximum weakness and discontinuity in the system occurs just when it should be at its strongest."

The discontinuities in service, financial support and comprehensive psychosocial care that occur between youth and adult services have become systemic problems that require immediate intervention. Research shows that at least 60 per cent of young people with enduring mental health issues disengage from service during the transition between the two systems.

Feedback from many stakeholders in Canada suggests that, overall, youth services are siloed from adult services. This is problematic, given research evidence, such as that published in a 2008 issue of the *Journal of Behavioral Health Services and Research* by Pottick and colleagues, which found that poor transitions "jeopardize the life chances of transition-aged youth (aged 16–25) who need to be supported to successfully adopt adult roles and responsibilities." We must learn how to best support youth transitioning from youth services to adult services and implement appropriate strategies.

The empirical evidence indicates that creating better linkages between systems requires formal transition services that focus on shared responsibilities in planning and flexibility in their application. In other words, transition interventions must be tailored to the needs and strengths of individuals and their families.

The Canadian context. As a critical part of model development, our research group has conducted studies with key stakeholders in youth mental health transitions. Researchers, policy leaders, youth, caregivers and care providers pooled their expertise and lived experiences with the goal of creating better linkages between the youth and adult mental health systems. The recommendations from our stakeholders closely aligned with best practices that promote well-being in youth and their families.

Merging stakeholder perspectives and recommendations with evidence gleaned from a review of leading transitional practices in health care such as the Good to Go Program at the Hospital for Sick Children and the Growing Up Ready Program at the Holland Bloorview Kids Rehabilitation Hospital (both in Toronto) resulted in a proposal to study a shared management model of service delivery for youth in transition. This approach to care involves close collaboration, stakeholder investment and the creation of transition teams and services to help youth navigate the journey. Currently, our group is piloting this project in the Ottawa area.

The Australian context. The best-known transition program internationally is Headspace (www.headspace.org.au). This program evolved as a community-based model of care to complement Australia's Orygen program, which features a specialized youth mental health clinical service, an internationally renowned youth mental health research centre and a youth mental health training and communications program (http://oyh.org.au).

Headspace promotes and facilitates improvements in the social well-being, economic participation and mental health of young Australians. This model of service delivery provides comprehensive care (including GPs, psychiatrists, psychologists, addictions counsellors, social workers and administrative personnel) in a single setting. The program considers developmental age and engages with the community to overcome eligibility constraints and service boundaries. Data from a 2009 preliminary evaluation supported the efficacy of Headspace as a transition program; however, the nature of the funding model for this structure would likely render it unfeasible in a Canadian public health care context.

Transitioning in the United Kingdom. National Service Framework protocol and reciprocal agreement templates were disseminated to care providers. These tools were intended to provide the foundation for a continuous care system for transitioning youth by acting as cost-effective service contracts to facilitate transitions. However, the efficacy of the approach has proved less than ideal, largely due to a pervasive policy–practice gap. Still, about 25 per cent of mental health service providers in the United Kingdom have identified specific transition agreements.

The shared management approach being implemented in Canada represents a middle ground between the intensive care provided by Headspace and the policy-directed protocol structure of the United Kingdom. Establishing a transition team as part of a shared cared approach marks a first in Canadian mental health. This approach closely reflects the model of service delivery proposed by the MHCC by helping to break down silos within the mental health system.

The Champlain Local Health Integration Network (LHIN), which services eastern Ontario, has provided funding to implement the shared management model to transition 110 youth with moderate to severe mental illness from youth to adult services. A transitions team, comprised of a co-ordinator and partner community and hospital providers, was formed. The co-ordinator position is funded through the Champlain LHIN, and the partner providers have all dedicated in-kind contributions to assist in linking youth services with adult services.

With the partner providers, the transitions co-ordinator and an advisory board of child, youth and adult allied health professionals and community care providers work with youth to develop a youth-driven care plan that provides a co-ordinated transition between services. If this model is implemented appropriately, it may help to establish a better standard of mental health care and act as the launching point for other youth mental health transition programs.

To assess the efficacy of this model, an outcomes-based evaluation platform was designed, which involves tracking tools, standardized measures and qualitative interviews. This platform represents a positive initial step toward developing a framework to evaluate and identify evidenced-based practice in youth mental health transitions.

Currently, we are using this platform to study our model and are working with other Canadian researchers and international collaborators to expand it. Our goal is to assemble an international network of transition researchers to create a common platform to help us compare the efficacy of international transition programs and identify evidence-based practices in the field. It's a big step toward helping young people on the path to adulthood. CC

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Dr. Simon Davidson is the regional chief of Specialized Psychiatric and Mental Health Services for Children and Youth at the Children's Hospital of Eastern Ontario/Royal Ottawa Mental Health Centre. He is also chair of the Child and Youth Advisory Committee with the Mental Health Commission of Canada.

Dr. Mario Cappelli is the director of mental health research at CHEO and a clinical professor of psychology and adjunct professor of psychiatry at the University of Ottawa.

Want to read about a unique addiction program for transition-aged youth? Access this issue at **www.camhcrosscurrents.net** and scroll down to the story called **"Growing up with no place to go."**

Teenage head

By Angela Pirisi

Adolescence conjures up the opening line from Charles Dickens's *A Tale of Two Cities*: "It was the best of times, it was the worst of times…." It's a period when the sense of adventure and discovery merge messily with distraction, sensation-seeking, emotional intensity and poor decision-making.

Fresh perspectives about adolescent behaviour have emerged as new inroads are made into understanding the adolescent brain. Over the last decade, thanks largely to advances in imaging technology, science has been starting to explain the baffling behaviour that makes parents and health professionals alike scratch their heads.

Any adult would agree that it's annoying and challenging to live through a major home renovation. For adolescents, that's exactly what they're going through—only it's happening in their brain. Contrary to the long-held belief that structurally the human brain is set like cement in early childhood, recent research has shown that this isn't the case.

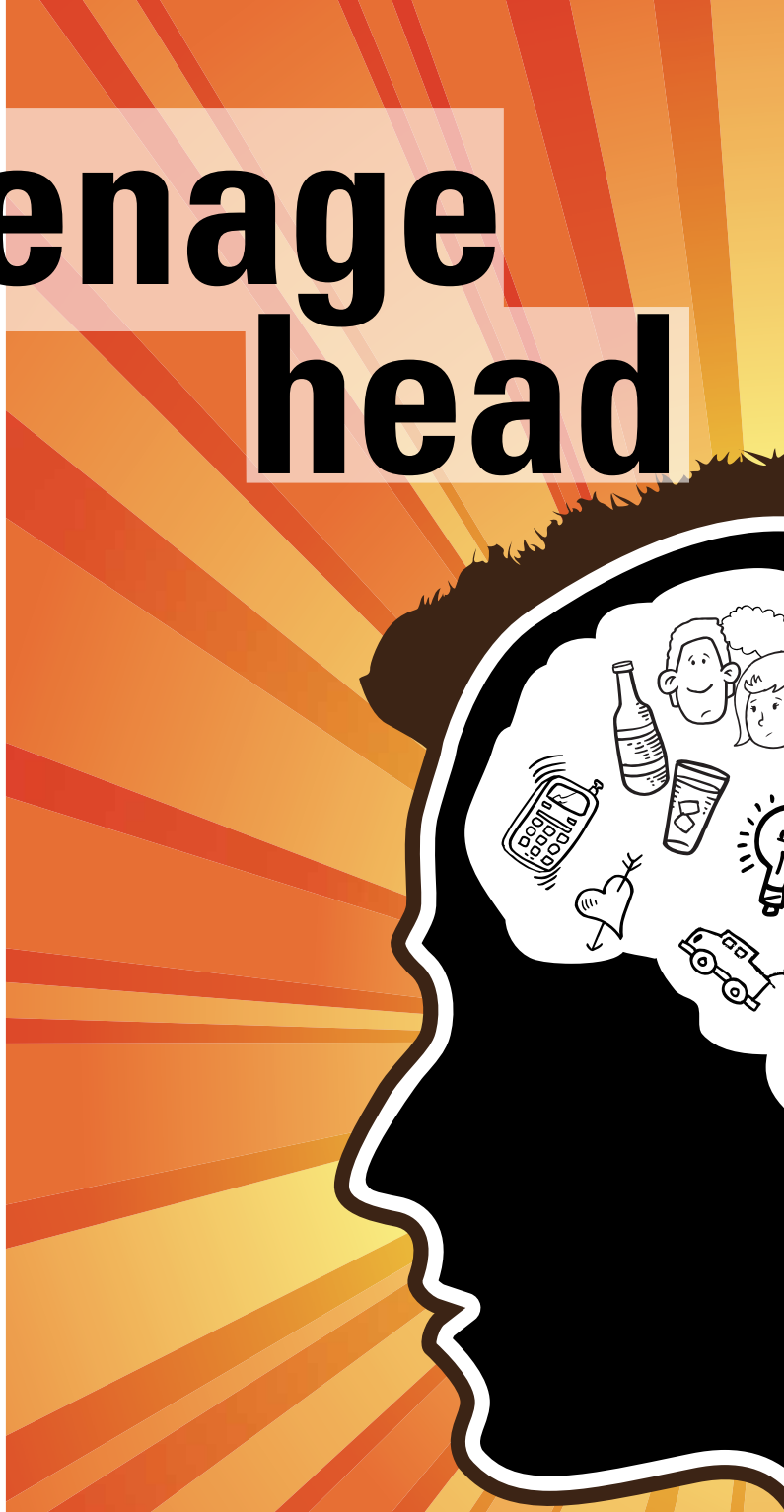
"It was believed that all major changes in the brain happened up until age 6 because by then, the brain is at about 95 per cent of its adult weight," says Dr. Jean Clinton, a child and adolescent psychiatrist and associate clinical professor in the Department of Psychiatry and Behavioural Neuroscience at McMaster University in Hamilton, Ont. But groundbreaking work begun in the late '90s by Dr. Jay Giedd, a neuroscientist at the National Institutes of Health in Bethesda, Md., revealed otherwise. Giedd initiated a longitudinal study that involved scanning the brains of young people every couple of years. What he saw was a change in the grey-to-white–matter ratio. "Other researchers then started looking at structural changes in the teen brain, and these changes are profound," says Clinton.

Dr. Deborah Yurgelun-Todd, director of the Cognitive Neuroimaging Laboratory at the University of Utah Brain Institute, sees these profound changes. "The brain weighs the same in a 12-year-old as in an 18-year-old, but how that tissue works and how it's sculpted is different," she says. The 12-year-old brain may be 95 per cent of its full-grown weight, but it's only halfway in its maturation process, which continues until about age 24.

So what's happening in there? Key changes have to do with what is known as proliferation and pruning. The grey matter, or "thinking part of the brain," as Giedd calls it, continues to thicken throughout childhood and peaks at about puberty (age 11 in girls and 12 in boys). By this time, the brain has sprouted thousands of new neuronal connections, much like the branches of a tree. The next stage is marked by pruning of the new connections and consequently a thinning of the grey matter—basically, connections that get used grow stronger, and less used ones get whittled away for good.

The structural changes that shape adolescent behaviour happen in many areas of the brain, but three are particularly noteworthy: the nucleus accumbens (responsible for reward-seeking behaviour), the amygdala and the prefrontal cortex. "Kids are terrific in that they're developing new skills and abilities, but they're very challenging because their reward-seeking and thrill-seeking systems are under construction, as is

Any adult would agree that it's annoying and challenging to live through a major home renovation. For adolescents, that's exactly what they're going through—only it's happening in their brain.



Why adolescence can be so baffling

executive function (which develops later than thrill-seeking)," says Clinton. "So there's a mismatch between reward drive and 'stop-and-think-about-it.'" That gap between doing and thinking is at the basis of so many accidental deaths and injury among youth, adds Clinton.

Since the nucleus accumbens is still immature in adolescents, it looks for maximum excitement using minimal effort, thus explaining why video gaming is such a common pursuit among teens. The amygdala is responsible for emotional responses, including the explosive behaviour often associated with turbulent teenagehood. It goes into a sort of overdrive during adolescence—in fact, studies show that adolescents use emotional processing a lot, applying an emotional lens when adults would rely on reason. The prefrontal cortex, the judgment part of the brain, undergoes changes as well, but it's the tortoise in the race. Although it is responsible for planning, setting goals and predicting the consequences of action, the prefrontal cortex is the last part of the brain to mature, which means that logic takes a backseat to visceral reactions.

In one study where adolescents underwent the Stroop interference task (which tests the ability to ignore interfering stimuli), results showed an age-related change in the prefrontal cortex. "As you mature from age 8 to 18, your ability to focus your attention improves. Using fMRI, we showed that activation differences in certain regions of the brain correlated with that improvement," says Yurgelun-Todd. "These findings are more about cognitive processes than affective or emotional processing, but they're still completely related to differences in mood and the ability to modulate affect because it is this change in frontal cortex that provides you with increasing skills to use judgment."

The dynamic state of the adolescent brain and the changes that occur are what increases the brain's potential, but they also render the brain vulnerable to adverse events. For example, studies have revealed that anxiety disorders, bipolar disorder, depression, eating disorders, psychosis (including schizophrenia) and substance abuse typically surface in adolescence.

Neurobiological changes that are part of normal adolescent development seem to coincide with the emergence of mental illness. For example, proliferation turns to pruning by early adolescence, which coincides with a period of higher vulnerability to schizophrenia. Dr. Martin Teicher, director of the Developmental Biopsychiatry Research Program at McLean Hospital in Belmont, Mass., suggests in his research that the pruning that is supposed to help fine-tune the brain could in fact be unmasking a congenital defect in people with schizophrenia. On the other hand, pruning in the striatum seems to coincide with the decreasing occurrence of attention-deficit/hyperactivity disorder and Tourette's syndrome in adolescence.

However, Dr. Martin Alda, an expert in mood disorders and a professor of psychiatry at Dalhousie University in Halifax, N.S., disputes the notion that mental illness often begins in adolescence. Currently, Alda and Dr. Anne Duffy, also a psychiatry professor at Dalhousie, are conducting research that looks prospectively at children who are genetically at risk for bipolar disorder, suggests that children often develop some symptoms earlier than in adolescence, but they aren't classic symptoms, so they may not meet diagnostic criteria. "Children may display early symptoms of bipolar disorder, such as periods of difficulty with sleep and anxiety, but it's only in adolescence that they usually develop symptoms of depression, and only in later adolescence or early adulthood that they develop symptoms of mania or hypomania," says Alda. "It seems as if

something is already happening in the brain, but the behavioural expression of what's going on depends on the person's age."

Yurgelun-Todd agrees that mental illness may often progress until symptoms are obvious enough to be diagnosed in adulthood. "Historically, we thought many of the serious mental illnesses were more adult problems; now we know they start to emerge over a number of years. For example, most individuals live seven years, on average, with bipolar disorder before seeking treatment," she explains.

> The dynamic state of the adolescent brain and the changes that occur are what increases the brain's potential, but they also render the brain vulnerable to adverse events.

What is less understood is the role of hormones in mental illness, says Alda: "Hormones in general, including cortisol, gonadal and sex hormones, are involved in mood regulation, so it's reasonable to assume that they play some role, but it's not clear exactly what that is." What we do know from data is that schizophrenia develops, on average, four years earlier in males than in females and that there is a 2:1 female to male ratio of depression rates at mid-puberty—the ratio is equal before puberty.

What we don't know, however, and what has been lacking in the research is longitudinal data that could show exactly what is happening in the brain structurally and functionally prior to the first symptoms or episode of mental illness, says Yurgelun-Todd. Adding another level of complexity is trying to tease out the interplay between surging hormones, structural changes in the brain and the shifting psychosocial environment that seem to coincide during adolescence.

The adolescent years seem to present a unique period of vulnerability to substance use issues as well. "Because adolescence is a period of high-risk engagement and taking chances, it's a time of opportunity, but also a time for negative, high-risk behaviour, one of which is substance abuse," says Yurgelun-Todd.

An immature prefrontal cortex, the seat of judgment, makes teens more impulsive and likely to try alcohol and other drugs. The reward-seeking nucleus accumbens makes them more likely to seek out activities with maximum reward and minimum effort—a quick fix—and want to repeat the experience, explains Clinton. Alcohol makes them feel more socially disinhibited, which leads to even more risk.

Substance use itself can alter brain development. The potential for brain damage is age dependent: the younger the brain, the more damage. "The chances of altering structural development are greater in adolescence," says Yurgelun-Todd, "and the neurotoxic events that might be associated with substance use are greater in adolescence than they appear to be in adulthood."

The good news is that the changing brain can be directed or redirected, just as a climbing vine can be coaxed along a trellis. Thanks to plasticity, that means that the brain's final blueprint can be greatly influenced by experience. For example, Clinton says we can speed up executive function, but societal norms also have to shift from the protracted period we view as adolescence and teenagehood. "We need to rethink how we view adolescence," she says. "In other cultures where young people are given responsibility, have intergenerational connection and have a sense of purpose within the society, there isn't the extended period of time we call adolescence, and there's less risky behaviour."

For those in the mental health care sector who work with youth, whether regularly or rarely, Clinton emphasizes that they "need to understand that the teen brain is changing in ways that are very much linked to some of the challenging behaviours we see—that concept of the brain under construction is central; for example, planning and organizing are under construction and executive function may not develop until age 25." Keeping that in mind helps when teen clients show up late for an appointment or without their health card for the fourth time, says Clinton. "What we think affects how we feel, how we act. If we see this as a skill 'under construction,' we can help them develop the strategies for organizing, rather than think it is non-compliant behaviour," she adds.

Yurgelun-Todd lends some perspective to working with youth who have substance use issues. "Depending on where they are in their addiction and their age, that will impact their cognitive-emotional processing, so you can't assume you're working with someone who can engage with you in the same way as someone not using those substances," she says. "The ability to read affect, to focus, to redirect energy if they've been engaged in drug use for a while will be limited."

Yurgelun-Todd offers more tips for dealing with youth, particularly those with mental illness or substance use issues: "Trying to oversimplify messages and repeat them more is probably the best way to work with these individuals. If you lost the last 10 per cent of every sentence you heard, what would your take-home message be? If you have an attention problem, you're not hearing every word or interpreting it the same way. Attention span will vary, motivation to engage in getting better will vary—and that's true for healthy adolescents compared with adults as well."

More than a century ago, eminent psychologist G.S. Hall described adolescence as a period of heightened "storm and stress." The question is: What determines how well youth weather that storm? The growing body of brain research is attempting to address that question by examining what happens in the course of normal development, as well as what can go wrong and how. But let's not get too cocky, says Yurgelun-Todd: "We have to be cautious about how much we think we know. We know that the brain is changing, that it's not fully mature and that it has some resilience, but we still have a lot to learn." CC

> The chances of altering structural development are greater in adolescence, and the neurotoxic events that might be associated with substance use are greater in adolescence than they appear to be in adulthood.

Daisies & bruises

When growing up is difficult

By Erin Schulthies

Like all kids, I was excited to grow up, but I never expected my teenage years to take the direction they did. Instead of growing into the world, I felt myself withdrawing as I experienced major depression and anxiety. My symptoms became unbearable when I turned 16—the age in Ontario when youth in the mental health system begin to switch to the adult system. I felt the change between the two systems immediately.

The biggest difference I found between youth and adult mental health services was the attitude of hospital staff. With children and youth, the goal is to help patients recover and move on to a healthier life. The adult mental health system, however, brings with it an air of nonchalance about your specific recovery. When I entered the psychiatry ward at 16, I felt like no one wanted to help me recover. Instead, the priority was discharge because there were so few beds to go around. I felt like a statistic more than a person and that deeply affected my sense of self.

The adult psychiatry ward houses people with a wide range of illnesses of various ages, but I've always been one of the youngest during my hospital stays (I'm now 26). At 16, it was particularly hard to be around the patients most disconnected from reality and it took me a long time to learn that I should trust no one. It's difficult because especially in our teens, our impulse is to connect with others for safety and comfort. It's terrifying for a teen to maintain any sense of self-worth when they are hospitalized alongside patients in a truly dangerous state.

It would have helped if staff had educated me about my rules and rights as a patient on the adult ward. My self-esteem was so low that I silently remained with roommates who bullied and controlled me because of my age.

My mental illnesses completely derailed my life as a young adult in terms of normal developmental challenges. At school, they caused a rift between me and my peers and later between me and my teachers. I could feel the stigma surrounding what I was going through and internalized it, resulting in me hating myself for being ill. There were weeks in high school when I was both a mental inpatient and a student, leaving the hospital in the mornings for school and returning once school was over. I lived a double life in which I couldn't focus wholly on my education or wholly on my recovery. I eventually gave up the former for the sake of the latter, and my life has been empty since then because there is nothing more disheartening than having mental illness as my only identity.

I couldn't work due to anxiety, low self-esteem and shame. When I was 19, my family convinced me to seek help in finding a job that would respect my mental health needs, but the employment agency I turned to didn't understand mental illness–related disabilities. I felt belittled and insulted throughout the process and left the agency feeling worse than ever.

I had worked exceptionally hard throughout high school with the goal of being accepted to one of my dream universities. Instead, I settled for applying to local schools so that if a crisis occurred, my parents would be within driving distance. I later could not even leave my hometown because I couldn't cope without seeing my usual therapist. When I half-heartedly applied to be a part-time student at the college in my city, I found that the disability services at the school didn't meet the needs of people with mental illness. I dropped out before the first week of classes was over.

Erin Schulthies creates collages as an expression of the art of living with depression.

I would love to see workers in the community learn more about mental illnesses and how to work with youth dealing with them. I feel that many people are so eager to appear non-judgmental that they completely ignore the diagnoses disclosed to them. I need the system to work with me by ensuring that service providers are open to hearing me speak about my experiences so I can educate them about my needs.

Until then I find great meaning through the youth organization mindyourmind (www.mindyourmind.ca) and my blog (www.daisiesandbruises.com), where I write about the art of living with depression.

From uncomfortably numb to feeling ALIVE

Overcoming the legacy of residential schools

By Rupert Ross

As a crown attorney serving more than 20 fly-in First Nations in northwestern Ontario for the last 26 years, I sometimes see Aboriginal youth who don't seem to care about anything, including themselves. Some carry an anger that suddenly explodes into violence, catching everyone by surprise.

My last major prosecution is a dramatic case in point. It involved two teenage boys who hosted a party when parents were away. When an older teen made advances toward the girlfriend of one of the boys, they attacked him. For about an hour, with other young people doing nothing to stop them, they repeatedly stabbed the older teen, inflicting a fatal wound. They then dragged him outside, hid his body and returned to the house, where one of the boys had sex with his girlfriend. The police found the two boys there the next morning. Neither expressed remorse in statements to the police.

It's easy to point to "surface reasons" for such behaviour. Extreme community and individual poverty has made some homes hugely overcrowded, forcing youth out into the community at all hours. Their homes are sometimes violent: Aboriginal spousal assault happens at five times the national average. I spoke with a young victim of child abuse who reported facing criticism from siblings: "We put up with it; what makes you so special?" It's easy to see the attraction of intoxication, whether by alcohol, drugs, gas-sniffing or the illegal consumption of prescription medication. Who wouldn't want to seek numbness from the pain of living in these conditions?

Over 26 years, Aboriginal healers and teachers have taught me that we need to look deeper than the surface reasons so Aboriginal communities can find their way back to health. My own journey to this awareness has been a long one that required me to be willing to move outside the narrow frame of criminal justice in which I have been trained as a lawyer. I found myself invited into the world of Aboriginal culture and healing. Aboriginal Elders and healers introduced me to a different worldview of healing and justice. Through sweat lodge ceremonies and the deep teachings of First Nations Peoples, I have come to see the problems in a different way. I have tried to acknowledge and communicate this hidden wisdom that is still carried by Elders and healers in my writings and in the frequent opportunities I have had to speak publicly about these problems and their solutions.

The wisdom of Aboriginal communities has taught me that understanding the issues some of their youth face today means understanding what happened to the five generations of children who preceded them. Many were taken to residential school at age 5 and didn't return home until they turned 16. It takes digging deeper still, beyond any physical or sexual abuse, to the incessant denigration of everything indigenous: language, spirituality, history, family structure, community governance systems—and their individual intelligence and potential in life.

School survivors speak about the shame they were made to feel. But they seldom speak about how they dealt with that shame—or with the loneliness, anger, fear and other emotions that arose during their captivity. They may have returned from the residential schools as near-adults in the physical sense, but they never had the chance to develop the emotional competencies they needed to process those feelings properly, and so those powerful feelings remain for many survivors. In turning to the values and practices of Aboriginal culture, I have seen how healing can happen. It requires developing the emotional competencies necessary to process old and new emotions, in addition to addressing the physical, spiritual and mental dimensions.

Emotional maturation involves developing skills in labeling and interpreting emotions as they arise, in being able to talk about, monitor and manage them. Those skills most often develop during childhood, within parent-child relationships of trust and caring. But when trust and caring are not part of the emotional environment, problems arise.

One of the most thorough examinations of emotional deficits comes from Lee Brown, director of the Institute for Aboriginal Health at the University of British Columbia (UBC) in Vancouver. In his PhD thesis, "Making the Classroom a Healthy Place: The Development of Affective Competency in Aboriginal Pedagogy," Brown related conversations he'd had with former Aboriginal students of an adult training program, where they regularly put course materials aside and spoke about the residential schools:

"We weren't allowed to cry. Because we were taught that way, it was really, really hard to cry, even laugh."

"I had built this wall around me … ever since I was small. I wouldn't allow anybody into that space of mine. I think it was really hard to take that risk, letting that down and letting people in."

They talked about having to *learn* to get in touch with, and then express, their feelings:

"What (the program) really did is it gave the group permission to feel … to feel their emotions and actually express them."

"The big thing is opening up and trusting, being able to talk about those feelings and being able to identify those feelings."

"Being given permission to cry and not have to explain why you were doing it, and people supporting that, just allowing you to do that, was a new experience to me."

In the 2008 book *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*, Joseph P. Gone reports one man's experience:

"Growing up, we were very seldom asked how we felt about anything. Very seldom would we be asked, "Well, how do you feel?" if we were crying.… I grew up not talking about my feelings, not knowing how, not really wanting to. So I was numb in that area."

That seems to be what too many of today's Aboriginal youth face: growing up without becoming emotionally engaged in healthy ways with their families or anyone else around them. They simply don't know how. Sometimes, what comes out instead is anger, violence or numbness. Is it any wonder that people carrying unprocessed anger, fear and pain turn to intoxication? Gone relates the experience of another man:

"That's the reason why I turned to alcohol, to numb the pain, because that's what it does, it numbs the pain. And so today we address social problems, and oftentimes right away we label it, "Well it's an alcohol problem or a drug problem." Personally, I don't see it that way. That person has an alcohol problem for another reason, for something bigger than that."

Maria Yellow Horse Brave Heart, an American Aboriginal educator, perhaps said it best in a 2005 issue of *Wellbriety! Online Magazine*:

"You shut down all feeling because you are trying to avoid the pain. It helps you get through the immediate crisis and the trauma. But if they persist, if they go on for a long time, they become a problem and you don't feel much of anything. You numbed yourself from the pain, but you stunted your feelings, your warmth and your joy."

Resources for helping Aboriginal youth

Aboriginal Healing Foundation
www.ahf.ca

Assembly of First Nations National Youth Council
www.afnyouth.ca

National Aboriginal Health Organization
www.naho.ca

Native Mental Health Association of Canada
http://nmhac.ca/

Seeds of Empathy program (emotional competence for children)
www.seedsofempathy.org

University of British Columbia Institute for Aboriginal Health
www.iah.ubc.ca

Lee Brown's students spoke about the aspect of healing that involves learning to monitor and manage their feelings:

"It is learning to listen, learning to express my feelings, express my opinion without getting angry, without getting upset."

"Now, if somebody bothers me I can tell them, 'I hear what you say and I don't think you should say that,' whereas before I would just let you say it and forget about it. Not really forget about it, but actually it would build up inside me and then I would just blow off at the next person."

"(The training program) opened doors to be able to see better, to hear better… to communicate more, more lightly or in a civil manner."

Instead of being stuck in stunted feelings, these students started to experience warmth and joy and become aware of healthier ways to express their feelings. Aboriginal communities are developing ways to help young people—and their parents—unlock and develop the emotional potential that socio-historical factors deep below the surface have kept buried and denied.

Rupert Ross is the author of *Dancing with a Ghost: Exploring Aboriginal Reality* (Penguin, 1992) and *Returning to the Teachings: Exploring Aboriginal Justice* (Penguin, 1995). He has travelled across Canada doing work with the Aboriginal Justice Directorate of Justice Canada and the First Nations and Inuit Health Branch of Health Canada.

Want to know what Aboriginal communities are doing to help young people develop emotional competence? Visit **www.camhcrosscurrents.net** and scroll down to the article called **"More than a feeling."**

CAMPUS IN CRISIS

Support services help students make the grade

By Avril Roberts

"Every semester I have this debate with myself: Am I going to warn people that I'm crazy and that I may go crazy during the semester and that I'm going to require specific kinds of assistance? Or am I going to shut up about it and see how it goes? If it goes well, they'll never know. And if it doesn't go well, I'll deal with it then."

That's how Elizabeth, a member of the Toronto-based Mad Students Society, describes her first experience at university. It's an experience that is becoming increasingly familiar to counsellors who work in college and university counselling and disability support services across the country.

At York University in Toronto, Mental Health Disability Services has seen a 52 per cent increase in student registration over the past five years, with 891 students in 2010/11. "Compared with students who have chronic (physical) illness and other medical disabilities, students with mental health disabilities represent the fastest growing population of students with disabilities on our campus," says Dr. Marc Wilchesky, executive director of Counselling and Disability Services.

"There is a perception among counselling centre directors that the severity and complexity of problems are increasing dramatically," says Dr. Rice Fuller, counselling director at the University of Fredericton in New Brunswick. The Center for Collegiate Mental Health, a consortium of college counselling centres based at Penn State University, is conducting large-scale research to examine the issues. The University of New Brunswick will be a participant, along with other Canadian universities.

Dr. Enid Weiner, manager of York's Mental Health Disability Services, agrees that student mental health is a growing concern: "Not only are more students presenting to disability offices; it's also a different population. We see students with schizophrenia, post-traumatic stress disorder, bipolar disorder and major depression, and we see a tremendous number of students with anxiety disorders." This is mirrored in the findings from the *Canadian Campus Survey 2004* and the *National College Health Assessment 2010* (U.S.-based but with some Canadian post-secondary institutions), which show that depression and anxiety are prevalent concerns.

Such findings don't come as a surprise. Immersed in a competitive environment and away from home and supports, often for the first time, students can have a hard time adjusting. For those with mental health problems, the pressures can be particularly challenging. University students interviewed for this story describe some of the obstacles they face:

Fear of discrimination. "To say what's wrong with me is in my mind a really risky move in academic places."

B**eing away from usual supports and resources.** "You come to university at 18. I was transitioning out of the youth health system, but I didn't have connections established yet in the adult system. The transition was huge."

Self-identifying as having a mental health disability. "I registered with disability services because it was seen as the responsible thing to do, and all of a sudden, I became a disabled student."

Coping with episodic illness. "Last year was a really tough year. I spent three months in hospital."

Lack of awareness of campus resources. "Academic accommodation wasn't available in high school, so I couldn't even begin to conceptualize what would be helpful."

Isolation. "I had moved to another city to attend university. I didn't know anyone. I found it difficult to engage in any of the communities on campus."

Managing symptoms and medication side-effects. "I was struggling, sitting in the library and crying most days."

Extra expenses. "I had to pay $3,500 for a psychological assessment so I could get academic accommodations. Just having the diagnosis wasn't enough."

Universities and colleges typically offer various levels of disability support and counselling and medical services. Brock University in St. Catharines, Ont., has taken it one step further. It may be the only university in Canada with a transition to university program that has a component specifically for students with mental health disabilities.

Students about to begin their first year can register for Smart Start, an academic orientation program the university runs for seven weeks in the summer. Students who indicate they have a mental health disability are contacted by the transitions co-ordinator from Services for Students with Disabilities, who explains the supports and academic accommodations available. Students who submit the relevant documentation are matched to a case manager. The first meeting happens during the orientation, with a follow-up recommended for early September, explains Mary Ann Gadula, the program's transition co-ordinator. Of the 119 students with a disability who participated in Smart Start in 2011, 22 had a mental health disability.

At York University, the primary focus of Mental Health Disability Services is to provide educational support. A major goal is to encourage students to become as independent as possible and become better self-advocates. Weiner is concerned that "many students are coming in with a diagnosis of anxiety disorder but no effective tools to handle it." And when reduced course load is suggested as a possible way to manage school demands and mental health, "some students get terribly offended," says Weiner. The program also offers psychoeducational groups and workshops on topics such as managing academic anxiety and procrastination that are open to all students.

Another valuable service is peer mentoring by upper-year students. Kristin, a graduate student and peer mentor, says the three biggest concerns she hears from first-year students are how to approach professors with an accommodation letter, including how much to disclose and how to handle potential negative reactions; what financial assistance is available; and social isolation.

At a commuter university like York, with more than 53,000 students, first year can be overwhelming. "If you are dealing with mental health issues and stress, you often don't have time to attend group support," says Kristin. "The peer mentor relationship becomes very important in helping to provide perspective for sorting through some of the chaos. Having one person who understands where you're at, where you're coming from and some of the things you experience can make all the difference in the world."

York's Counselling and Disability Services offers personal counselling services, usually short-term counselling, mainly for crisis situations, and learning skills services for students with all types of disabilities; however, it lacks staff who can assist students with medication management.

McGill University in Montreal, Q.C., offers full psychiatric services on campus, short of hospital beds. With 21 professionals (11 psychiatrists, plus psychologists and psychotherapists, many of them part-time), the Student Mental Health Service is well-equipped to deal with clinical issues. Anxiety and depression top the list, but the clinic is also seeing more students who have had psychosis. "Because of advances in medication, these students are able to continue their academic work," says Dr. Robert Franck, the clinic's director.

Access to services is relatively quick. "We try to keep it to a two-week maximum wait because two weeks is a fair length of time in a semester, especially when students are struggling," says Franck. There is an emergency drop-in for crisis. Short-term therapies such as cognitive-behavioural therapy and short-term dynamic therapy are offered, as well as medication management. Students who need long-term therapy are referred to community resources.

About 1,200 first-year students visited the clinic last year. Many are encouraged to also seek help from other campus resources such as the Counselling Service, the McGill University Health Centre and the Office for Students with Disabilities.

> "It's possible to go through school as a mad person, and it's possible to experience periods of distress, press on and just continue."

In the only program of its kind in Canada, McGill has a fully integrated university-based eating disorders program for students with mild to moderate eating disorders. It is staffed by two psychiatrists, a nutritionist and a nurse and treats about 100 students a year. Franck says this kind of service is critical because "untreated anorexia is one of the most fatal conditions in psychiatry, with a 20 per cent mortality rate." Students with severe eating disorders are referred to Douglas Hospital for treatment and monitoring.

On the other side of the country, the University of British Columbia (UBC) in Vancouver is taking a systemic approach to student mental health with a comprehensive student mental health plan. "The overall aim is to create a mental health–promoting campus culture and environment," says Dr. Cheryl Washburn, director of Counselling Services. The plan, which is in the process of being rolled out across campus, involves three levels: prevention, identification and intervention.

The prevention level addresses mental health awareness through the B.C.-wide Healthy Minds/Healthy Campuses project, led by the Canadian Mental Health Association–B.C. Division and the Centre for Addictions Research of B.C. It includes strategies for building a supportive campus environment, for example, through peer programs that facilitate a sense of belonging. Suicide prevention measures are threaded throughout the mental health plan and include training student residence advisors to identify students at risk.

Identification targets students who need to enhance their skills to function well on campus but who do not necessarily require professional assistance. UBC will launch an early alert system this winter. The goal is to train all faculty and staff to identify students with difficulties as early as possible and connect them to supports. The Live Well, Learn Well website promotes mental health awareness and skills development and supplies information about campus resources. Students are also routinely screened for depression at both Counselling Services and Student Health, whether they are seeking help with relationship problems or flu.

The intervention level targets students who need professional assistance. Two years ago, Counselling Services implemented a rapid access system, providing students with a same-day initial appointment. Recently, the clinic hired a case manager to assist students with complex mental health needs who require referrals to multiple services on campus or in the community. For instance, if a student is hospitalized, the case manager liaises with the hospital to discuss the student's discharge and ensures that appropriate supports are in place to facilitate the student's return to school.

"We look at the specific changes that students identify they need to get back on track and follow through with their academic term, and we consider what combination of resources would best help," says Washburn. "Unless there are issues of risk, the student is the one empowered to make those decisions."

Progress is also being made at the national level. Realizing that mental health issues on campus cannot be the responsibility of counselling services alone, the Canadian Association of University and College Student Services struck the National Working Group on Post-Secondary Student Mental Health in 2011. As described by Washburn, who serves as co-chair, the working group has two main aims: to develop a systemic post-secondary student mental health strategy and to develop a community of practice to support implementation.

This is good news for students with mental health issues. Those interviewed for this story agree that completing college or university should be an attainable goal. "I was experiencing pressure that I had to leave school, drop out of life and get well, then come back and stay well for four years," says Elizabeth, who is now at York University. "That's like taking away hope from people and discouraging them from pursuing their goals. People have a right to go to school, take a leave of absence if they need it, get accommodation if they need it and be provided with support. It's possible to go through school as a mad person, and it's possible to experience periods of distress, press on and just continue."

10 questions to explore with clients contemplating higher education

1. Why do you want to go to school? What do you hope to accomplish?
2. Is education a priority for you? Is there anything else that needs to be a higher priority for you right now?
3. Is your illness sufficiently stabilized to allow you to concentrate on your education?
4. What was your previous experience with higher education? Do you have any issues you need to resolve from that experience?
5. How much do you know about the demands of academic life, such as navigating a campus, using a computer, taking notes, reading and writing assignments or taking exams? Do you need to find out more?
6. What are your strengths? How can you use those to your advantage?
7. What are your physical, intellectual and emotional needs? Do you know how to meet those needs?
8. Do you have the persistence and confidence to face frustrations, get the information you need from school administrators and advocate for yourself if necessary? If not, can you get a support person to help you?
9. Can you stick to your educational goals for at least one semester?
10. If your situation changes, will you be able to reassess and adjust it accordingly?

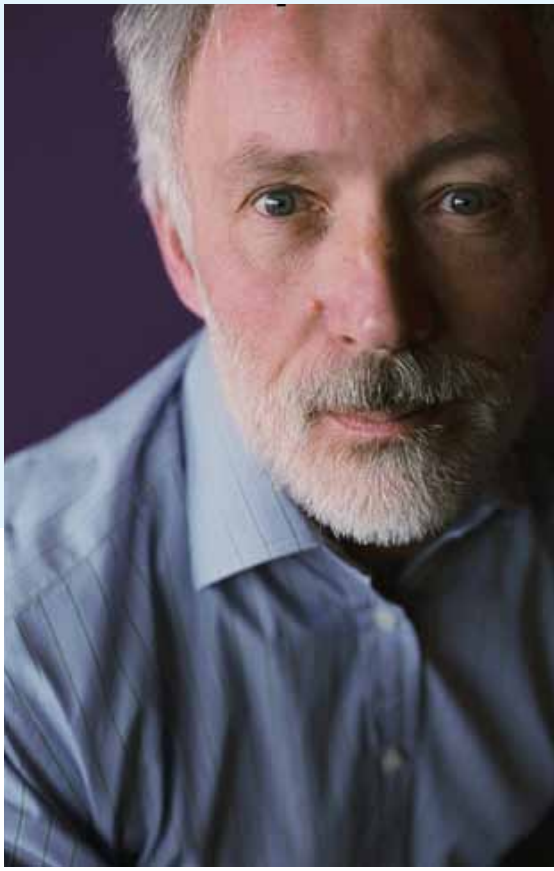
Adapted from *Your Education, Your Future: A Guide to College and University for Students with Psychiatric Disabilities*, Canadian Mental Health Association, 2004.

Transition-aged youth need distinct culture of care

By Amanda Dale

Youth mental health reform has been at the top of Dr. Patrick McGorry's agenda for 27 years. He is the executive director of Orygen Youth Health (OYH), a world-renowned mental health organization for young people that has put Australia at the forefront of innovation in preventing and treating mental illness in youth. OYH targets the needs of young people with emerging serious mental illness and has become the model upon which many other youth mental health services in the world are based.

McGorry is also a founding member of Headspace, probably the best-known transition-aged youth program in the world. *CrossCurrents* interviewed him about his work.



Dr. Patrick McGorry's work in Australia has served as a model upon which many other youth mental health services in the world are based.

Why does the transition-aged youth population merit specific focus in mental health programming?

"Transition-aged youth" (TAY) generally refers to a marginalized group of young people within the range of what I think is better termed "emerging adults," a group that universally warrants a distinct culture of care. Emerging adulthood starts earlier and ends later than the traditional TAY designation; we are discovering that many young people are not ready for the full responsibilities of adulthood until their late 20's. It is a critical age, which marks the peak of onset of all the major mental health disorders. It is the group with the highest mental health needs but with the least access to services and interventions.

TAY services in North America tend to focus on those youth with pronounced experiences of abuse, neglect and trauma. We do that work as well, and it is important work. But there is a broader spectrum of youth that needs access to a distinct culture of care.

What constitutes a "distinct culture of care" for emerging adults?

If you think of the waiting room in a children's mental health service, there are toys, dolls, crayons. Children are brought in by their parents. They experience a range of disorders like autism and ADHD. But for emerging adults, there is a distinct culture of care and the disorders are different. Clinicians need different engagement approaches, and while parents still have to be involved, we don't require them to come with their kids. The range of expertise and the resources clinicians need to be engaged with these youth are totally different: drug and alcohol treatment, employment programs and so on.

As for adult services, they are primarily geared to middle-aged people, and young people do not have the right diagnostic entry tickets. They are frightened by being in the company of 45-year-olds with chronic illnesses. The clinical skills required for work with young people are quite different, and adult services do not always acknowledge that this disconnect is happening for these young adults.

What makes the programs of Headspace a unique service for emerging adults with mental health issues?

Any young person can come to Headspace, which is a youth-friendly café shop-front setting. They can talk to youth workers or a GP as the first step—have someone listen sympathetically and get information and feedback If they need more professional care, it is available in a multidisciplinary team model in a low-stigma setting The usual issues that the youth present are anxiety, depression, relationship issues and drug and alcohol problems, usually in combination. We use a clinical staging model that seeks to define the extent of the young person's mental health problems along a continuum from asymptomatic to increasingly severe. This staging model can be used to tailor each young person's care and allow interventions to be matched to their illness course (or stage) by understanding and monitoring their vulnerability (for example, exposure to stress or trauma); early symptoms; the established illness trajectory and a recovery phase.

There are many ways for youth to connect with help, including multi-media expression, social media links, musicians' endorsements of our centre and downloads of their music, as well as plain language blogs and other forms of information, research and support, all of which make it more approachable. There are 40 centres throughout the country; there will be 90 by 2016.

Traditionally, the doctor is considered the expert. Do you take a different approach?

We have a model that values youth participation. In our Orygen service, a dozen or so young people provide peer support, have advocacy and media roles and are involved in developing feedback and recommendations for care. It can be threatening to professionals when families and young people have more say. There can be tension about who gets to resolve the issue when there are differences. But this is a very healthy tension in the work. But this is a very healthy process. Often in adult services, consumer input can be tokenistic. Often adult survivors have had terrible experiences that make them very angry. Often they are also very debilitated. But young people are so resilient and those who make positive recoveries have a lot to give back. They have such positive energy.

For young people who have experienced trauma—where power has been taken away from them—is there healing power in the experience of having a say in their care?

Absolutely. When young people come to our space they talk about the experience of being empowered and respected. The services are designed and delivered with tremendous respect for them. This is not a top-down model. It also builds respect from the young people for the treatments. Some critics and even some colleagues misunderstand and sometimes misrepresent what we are doing and say we are medicalizing young people's options. But that's the opposite of what we are trying to do. We take a holistic approach, which does include respect for medical approaches and expertise in complex problems. The young people themselves do not have express this criticism.

How were you able to translate your clinical experience and research results into something taken up by policy makers?

I was fortunate to be honoured with the Australian of the Year Award in 2010, which gave me access to a lot of politicians, policy makers and media. But really, it's such a simple argument that's backed up by evidence. It is well supported by unbiased people who don't have an interest to protect.

There has been a backlash, primarily from small groups of dissatisfied professionals, but for the most part there is great interest, including in Canada. Most honest people in the mental health field recognize that we need novel approaches and transformational reform. The Jigsaw Centre in the Irish city Galway is run on a similar model. In some ways, the success mirrors the success with early intervention reforms in Canada and other countries with respect to psychosis. The reforms we are advocating arise from evidence-based research with academics, clinicians, researchers, families and youth.

What feedback do you hear from youth and families?

We do regular consultations; we have some research results, and we have a formal complaints mechanism and feedback process, which allows us to monitor and adjust programs as we go. An independent evaluation of headspace showed a 93 per cent satisfaction rate with the service model.

Currently, psychologist Rosemary Purcell is leading a transitions study in which other researchers and I are involved that will evaluate the headspace program and later the Orygen model more systematically. It will test our theoretical framework, the "clinical staging model," that seeks to define the extent of a young person's mental health problems along a continuum, from those at increased risk of developing mental illness but who are not yet showing symptoms to those experiencing mild mental health problems and those with increasingly severe mental disorders. Most participants in the study will have depression and anxiety symptoms, sometimes co-occurring with substance use and personality issues. A smaller group will have more severe disorders such as mania and psychosis.

Participants in the Transitions Study will be assessed at baseline, then followed-up annually for five years to examine what factors predict improvement and what factors predict worsening symptoms, particularly transitions between different stages of illness, including the role of headspace interventions. Within the overarching framework of the study, several smaller nested studies will be established to test the effectiveness of low-intensity interventions to reduce depressive and anxiety symptoms and prevent progression to more severe or persistent depression and anxiety.

There seems to be a lot of interest in your model. Do you have advice for starting up similar programs in other jurisdictions?

Come with a prototype. Professionally work out a plan in consultation with all the stakeholders. Remind everyone that this is a major mental health gap. And the effect of this gap is not restricted to young people. By not getting help for these young people, society in general weakens. You need to build community support and develop a systematic campaign that includes families and consumers working in partnership. You need a strong mission, a clear vision, allies and a professional model. Demonstrate what you can do with research and then move to a full scaling-up of programs. I'd love to assist if there is any help I can offer for developments taking place in Canada.

Resources about transition-aged youth

Headspace
www.headspace.org.au

MacArthur Research Network on Transitions to Adulthood
www.transad.pop.upenn.edu

Orygen Youth Health
http://oyh.org.au

National Network on Youth Transition for Behavioral Health
www.tipstars.org

Pathways to Positive Futures
www.pathwaysrtc.pdx.edu

Society for the Study of Emerging Adulthood
www.ssea.org

Exposing the art of addiction

Addiction science cultivates visual art as an advocacy tool for social change in a new book titled *Addiction and Art.* Published by Johns Hopkins University Press as a companion text to *Addiction Treatment: Science and Policy for the Twenty-First Century*, this new volume is intended to mark an intersection of science and visual art. It presents 61 artworks by 57 artists, accompanied by deeply personal artist statements. The editors, who come from psychiatry or art education backgrounds, position the book as a tool for advancing our understanding of addiction, which they argue is one of the major public health issues of our time.

The impetus for the book is rooted in a series of juried art exhibitions that were held over five years in conjunction with national substance abuse conferences. These exhibitions were funded by a national program initiated by Innovators Combating Substance Abuse at the Johns Hopkins University School of Medicine. Inspired by valuable lessons from the HIV/AIDS community, which has successfully used art to portray the human experience of the disease, Addiction and Art similarly strategizes to use art to change how we view addictions and substance use issues. The art in the book was selected by a panel of addiction scientists, artists and professional curators from more than 1,000 submissions received in response to a national call for artwork responding to a theme of drug addiction and recovery.

The resulting collection reflects all types of addiction, including legal drugs, illegal drugs and addictive behaviours and disorders. It includes a broad spectrum of real-world experiences, including artworks by people recovering from addiction, as well as by family members, friends and health care workers. The collection showcases paintings, sculpture, drawings, photography and other mediums. The accompanying artist statements strive to broaden our understanding of the works and to provide insight into the personal experiences of the artists.

The goal of the selection panel was to present a group of artwork that would address all aspects of addiction "from its allure, to its destructiveness, to new life found in treatment of recovery." Another aim was to reveal the social and cultural implications of these illnesses. The art and stories are honest, raw and challenging. Those created by people in recovery are especially rich in their complexity and imagery. Many, such as *Neonate Alcoholism*, are disturbing, challenging, even grotesque. Some stark, conceptual works are powerful in their blunt messaging, such as *0 Refills Left* (both pictured here).

▲ *Neonate Alcoholism*, Amanda Alders, 2008, acrylic on canvas, 24" x 36." Courtesy of Johns Hopkins University Press.

◀ *0 Refills Left*, Derek Cumings, 2008, mixed media, discarded medication, toy gun, 4" x 7" x 4.5." Courtesy of Johns Hopkins University Press.

As a whole, this collection reveals the complexity of addiction issues, particularly in the accompanying statements, where many of the artists expressed that creating these works has in itself been a tool on the path to recovery. Many of the works by friends and family are clearly cathartic, often with the unfortunate result of seeming cliché. Where the collection risks failing to achieve its intent to engage individual readers to move beyond stigma and stereotypes is that it is so successful in revealing the sadness, despair, self-reflection, angst, pain and remorse that afflicts those suffering from their own or a loved one's addiction that it could actually reinforce stereotypes. Messages of hope and success in recovery are virtually absent in these artworks.

It's not entirely clear who this book is for. The editors say it is not intended to be part of a treatment program, but they hope it will inspire friends and family, people with addiction, policymakers and scientists. The impact of the artworks is hampered by the textbook format. It doesn't feel like a coffee table art book intended for mass distribution, which it would need in order to achieve the societal shift in attitudes achieved by art projects like the AIDS Memorial Quilt. But it could inspire a group of individuals to conceive of and realize a project that would have that impact.

Addiction and Art. Patricia B. Santora, Margaret L. Dowell, and Jack E. Henningfield, eds. Baltimore, MD: Johns Hopkins University Press. 2010, 160 pp., $29.95US.

Lisa Brown is executive/artistic director and founder of Workman Arts in Toronto.

Chris Mitchell is visual arts manager at Workman Arts.

Lost in transition: Emerging adults and their families face many challenges

Shelly Ben-David

Parents hope their children will grow up to be successful members of society. A parent's worst nightmare is seeing their child winding up homeless, without prospects of career or family. I'm not a parent, but as a social worker who over the years has worked with young adults with severe mental illness, as well as their parents, I have witnessed the desperation that parents feel when their child is at risk for severe mental illness. For two years, I have been working at the Center of Prevention and Evaluation (COPE) research clinic at the New York State Psychiatric Institute, which follows adolescents at risk for developing psychosis. I have worked with young adults who are on the cusp of their first psychotic break and listened to their stories—some hopeful, many filled with confusion, sadness, and feelings of alienation.

Adolescence is a period of major development, when many biological, psychological and social changes occur. Developmental psychologist Erik Erikson defined adolescence as a stage that involves grappling with identity formation and role development. The task of the teenager is to individuate from family and become a member of wider society. In the stage that follows adolescence, young adults seek companionship and love and consider parenthood. But at COPE, I see young adults who because of their symptoms and their difficulty achieving developmental milestones—finding work, establishing relationships, living on their own—experience a sort of prolonged adolescence.

For many teenagers and young adults struggling with severe mental illness, achieving these developmental milestones is a big struggle. Research shows that mental health problems increase during adolescence, when more complex disorders like psychosis begin to emerge. As these individuals reach young adulthood, plans for separating from family, establishing meaningful relationships and finding a vocation become difficult because these young adults often rely on their families to take care of them. At the same time, they also face the transition from child-serving to adult-serving health care systems, with their rigid age boundaries. This health care transition often coincides with developmental transitions and increases the chances that youth with mental health problems will get lost in the transition between systems of care. How are families, particularly those from a lower socio-economic background, able to financially provide care for their children, especially if there are no programs to ease the transition to adult services?

How are families, particularly those from a lower socio-economic background, able to financially provide care for their children, especially if there are no programs to ease the transition to adult services?

In the United States, many children and adolescents with disabilities qualify for supplementary security income (SSI). But in order too continue to qualify for benefits as an adult, those who received SSI as children must go through a process of "redetermination" of eligibility. Johnson and colleagues interviewed youth and their families who had gone through this process and found limited understanding about the process of redetermination and the steps required. Families and young adults also expressed a lot of confusion about the different types of benefits they could receive. The findings, published in a 2007 issue of *Policy Research Brief* from the University of Minnesota, also showed that health care providers and school counsellors also had limited knowledge about this transition in support.

Educating families and health care providers can make the difference in determining whether young people can keep their status and financial and medical support as they transition into adult health care systems. SSI benefits are necessary for families living on limited means—they need the money to pay for rent, treatment and basic living expenses. One common fear for young adults, as well as their families, is that if they work, they may lose their SSI benefits. This fear is a disincentive to employment, so these young adults are less likely to get work and integrate into society, thereby failing to achieve important developmental goals.

I was first introduced to the phenomenon of psychosis as a first-year undergraduate when I volunteered at the Center for Addiction and Mental Health in Toronto. I ran yoga and meditation groups with patients, many of them young adults, in the early psychosis unit. I remember thinking how scary it must be to be a psychiatric inpatient. Yes, these young people were there to get help, but I wondered what happened after they left the hospital. Were they able to resume their lives?

In a study published in 2007 in the *Journal of Behavioral Health Services and Research*, Pottick and colleagues found that for transition-age youth with mental health problems, the rate of admission to outpatient services declined, while the rate for inpatient admission increased dramatically. As more youth are hospitalized and treated in an inpatient setting, they are at increased risk of trauma and misdiagnosis, as well as inordinate reliance on antipsychotics, with their marked side-effects.

At the COPE clinic, where I work with adolescents at risk for psychosis, we strive to normalize and de-stigmatize what the young adults we see experience. We provide clinical services for young adults and their families, in the hope that if they do become psychotic, they will have a more positive outcome and trajectory to recovery. We need better collaboration and coordination between adolescent and adult systems of care, so that young adults facing the transition don't fall through the cracks during one of the most important developmental periods of their lives.

Shelly Ben-David is a licensed social worker for the State of New York. She is also research coordinator at the Center of Prevention and Evaluation at the New York State Psychiatric Institute/Columbia University.

CANADA

22nd Pacific Coast Brain Injury Conference
February 15–17, Vancouver, British Columbia
tel 604 984-6448
fax 604 984-6434
e-mail conference@brainstreams.ca
www.brainstreams.ca/conference

International Neuropsychological Society 40th Annual Meeting
February 15–18, Montreal, Quebec
tel 614 263-4200
e-mail bornstein.1@osu.edu
www.the-ins.org/future-meeting-of-ins

American Association for the Advancement of Science Annual Meeting
February 16–20, Vancouver, British Columbia
tel 202 326-6450
e-mail meetings@aaas.org
www.aaas.org/meetings

Canadian Association of Drug Treatment Court Professionals International Training Conference
February 29–March 2, Toronto, Ontario
tel 780 437-8013
fax 780 439-6879
e-mail dorothy@cadtcpconference.com
www.CADTCPConference.com

6th Annual Quality Worklife Quality Healthcare Collaborative Summit
March 1–2, Vancouver, British Columbia
tel 613 738-3800
toll free 1 800 814-7769, ext. 448
fax 613 738-7755
e-mail sally@f2fe.com
www.qwqhc.ca

20th World Family Therapy Congress
March 21–24, Vancouver, British Columbia
tel 309 786-4491
e-mail info@ifta-congress.org
www.ifta-congress.org

5th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder
April 18–21, Vancouver, British Columbia
tel 604 827-3112
fax 604 822-4835
e-mail ipcde2@interchange.ubc.ca
www.interprofessional.ubc.ca/Adults.html

Providence Health Care Conference: Spirituality, the Invisible Ingredient in Health and Healing
May 3–4, Vancouver, British Columbia
tel 604 806-9090
e-mail eturtle@providencehealth.bc.ca
www.providencehealthcare.org

International Society for the Study of Behavioural Development Conference
July 8–12, Edmonton, Alberta
e-mail questions@issbd2012.com
www.issbd2012.com

1st National Family Mental Health Conference / 1st International Young Carers Congress / 3rd International World Congress on Children of Parents with Mental Illness
May 6–8, Vancouver, British Columbia
tel 604 827-3112
fax 604 822-4835
e-mail katia.ipce@ubc.ca
www.interprofessional.ubc.ca/CYMHM/default.asp

14th World Congress of the International Association for the Scientific Study of Disabilities
July 9–14, Halifax, Nova Scotia
e-mail vianne.timmons@uregina.ca
www.iassid.org/conference

Canadian Psychiatric Association 62nd Annual Conference
September 27–29, Montreal, Quebec
tel 613 234-2815
e-mail conference@cpa-apc.org
www.cpa-apc.org

3rd International Conference on Violence in the Health Sector
October 24–26, Vancouver, British Columbia
e-mail conference.management@freeler.nl
www.oudconsultancy.nl

UNITED STATES

American College of Psychiatrists Annual Meeting
February 22–26, Naples, Florida
tel 312 662-1020
e-mail angel@ACPsych.org
www.acpsych.org/meetings-and-news/annual-meeting

American Association of Directors of Psychiatric Residency Training Annual Meeting
March 8, San Diego, California
tel 717 270-1673
e-mail aadprt@verizon.net
www.aadprt.org

Society for Research on Nicotine and Tobacco Annual Conference
March 13–16, Houston, Texas
tel 608 443-2462
e-mail info@srnt.org
http://srnt.org/conferences/future/index.cfm

American Association for Geriatric Psychiatry 25th Annual Meeting
March 16–19, Washington, DC
tel 301 654-7850
fax 301 654-4137
e-mail main@AAGPonline.org
www.aagpmeeting.org

American Counseling Association Annual Convention
March 21–25, San Francisco, California
e-mail rhayes@counseling.org
www.counseling.org/Convention

American Neuropsychiatric Association 23rd Annual Meeting
March 21–24, New Orleans, Louisiana
tel 614 447-2077
fax 614 263-4366
e-mail anpa@osu.edu
www.anpaonline.org/2012-annual-meeting

Society for Research in Human Development 18th Biennial Conference
March 22–24, New Orleans, Louisiana
tel 202 336-5500
toll free 1 800 374-2721
e-mail convention@apa.org
www.apa.org/news/events/2012/srhd.aspx

6th Biennial National Conference on Health and Domestic Violence
March 29–31, San Francisco, California
tel 415 678-5500
e-mail amarjavi@futureswithoutviolence.org
www.nchdv.org

Anxiety Disorders Association of America 32nd Annual Conference
April 12–15, Arlington, Virginia
tel 240 485-1031
e-mail membership@adaa.org
www.adaa.org/resources-professionals/32nd-annual-conference

Academy for Eating Disorders International Conference
May 3–5, Austin, Texas
tel 847 498-4274
e-mail aed@aedweb.org
www.aedweb.org/AM

American Psychiatric Association 165th Annual Meeting
May 5–9, Philadelphia, Pennsylvania
tel 703 907-7300
toll free 1 888 357-7924
e-mail apa@psych.org
www.psych.org

25th Annual Northwest Conference on Behavioral Health and Addictive Disorders
May 30–June 1, Seattle, Washington
tel 954 360-0909, ext. 220
toll free 1 800 851-9100, ext. 220
www.usjt.com

18th Annual International Stress and Behavior Neuroscience and Biopsychiatry Conference
June 22–24, New Orleans, Louisiana
tel 240 899-9571
e-mail isbs.congress@gmail.com
http://stressandbehavior.com/nola2012.html

American Psychological Association 120th Annual Convention
August 2–5, Chicago, Illinois
tel 202 336-6020
e-mail convention@apa.org
www.apa.org/convention/index.aspx

ABROAD

4th International Gambling Conference
February 22–24, Auckland, New Zealand
e-mail cynthia.orme@pgfnz.org.nz
www.internationalgamblingconference.com

20th European Congress of Psychiatry
March 3–6, Prague, Czech Republic
e-mail epa@kenes.com
www.epa-congress.org

Alzheimer's Disease International 27th International Conference
March 7–10, London, United Kingdom
e-mail info@alz.co.uk
www.alz.co.uk/ADI-conference

19th International Symposium about Current Issues and Controversies in Psychiatry: New Approaches in Depression
March 22–23, Barcelona, Spain
e-mail admin@geyseco.es
www.geyseco.es/controversias/index.php?idioma=en

World Association for Infant Mental Health World Congress
April 17–21, Cape Town, South Africa
e-mail congress@waimh.org
www.waimh.org/i4a/pages/index.cfm?pageid=3298

International Society for Affective Disorders Conference
April 18–20, London, United Kingdom
e-mail isad@kenes.com
www2.kenes.com/isad2012

8th International Conference on Psychiatry Comorbidity within Psychiatric Disorders and Medical Illnesses
April 24–26, Jeddah, Saudi Arabia
e-mail psy1.jed@sghgroup.net
bit.ly/pVeQto

International Association for Child and Adolescent Psychiatry and Allied Professions 20th World Congress
July 21–25, Ile-de-France, France
e-mail iacapap2012@clq-group.com
http://iacapap.org/world-congresses

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